

**PLAN TO PLAN CHANGE**

**Please use this form for any of the following changes:**

- Change in Personal Information - Complete Sections 1 and 3
- Change Medicare Supplement Plan\* - Complete Sections 1, 2a and 3

*\*Complete application is needed for any change requiring underwriting.*

- Change in Select Coverage - Complete Sections 1, 2b and 3
- Remove Prescription Drug Coverage - Complete Sections 1, 2c and 3

**Premium must be paid for the existing plan up to the effective date of requested coverage change.**

**1. Personal Information (Please print and use black ink only)**

Last Name		First Name			MI	
Home Street Address		City	County	State	Zip Code	
				CA		
Billing Address (If different from above)		City			State	Zip Code
<input checked="" type="checkbox"/> Check here if all correspondence should be mailed to the billing address						
Phone Number		Social Security Number		Date of Birth		
Anthem Blue Cross ID Number			Medicare Claim Number			

**2. Coverage Selection**

**2a.  I would like to change my enrollment to the following Medicare Supplement plan.**

*(Check one only)* **PLAN TO PLAN CHANGE**

- Plan A  Plan F  High Deductible Plan F  Plan G  Plan N
- Pre-65 Plan A  Pre-65 Plan F

**Start Date:** \_\_\_\_ / 01 / 2011

**2b.  I would like to change my enrollment from a SELECT Medicare Supplement plan to a Non-SELECT Medicare Supplement plan.**

*(Check one only)*

- Plan A  Plan F  High Deductible Plan F  Plan G  Plan N

**Start Date:** \_\_\_\_ / 01 / \_\_\_\_

*Generally, the coverage start date will be the first of the month following receipt and processing of this form, unless a later start date is requested above.*

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción. M0013\_07\_05/2007

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**2. Coverage Selection** *(continued)*

2c.  I would like to remove the prescription drug coverage from my current Medicare Supplement plan

Medicare Part D effective date: \_\_\_\_ / 01 / \_\_\_\_

Medicare Part D carrier: *(Optional)* \_\_\_\_\_

*This change will coincide with your Medicare Part D enrollment effective date.*

**We will issue a new policy to you that outline the benefit changes.**

**3. Certification** *(Must be signed and dated to avoid delays in processing)*

I certify that I have read, or had read to me, this completed form. I understand that any untrue answer or statement made within this form may be material to the risk assumed by Anthem Blue Cross and may prevent the recovery of benefits under the plan. Such answer or statement may also result in the termination or voiding of the coverage back to its effective date. I understand that any information shown on this coverage change form that differs from what I wrote on my original application shall amend my original application.

I understand that a change in my area of residence may cause a change in my premium. The new premium due to a change in my area of residence will be effective no earlier than the first of the month following the address change.

Signature of Applicant, or Authorized Representative (if applicable)\*

Date

X

X

If a legal representative signs on behalf of the applicant, a copy of the legal representative's authority must be provided. This authorization is subject to revocation at any time by written notice to Anthem Blue Cross except to the extent that Anthem Blue Cross has already taken in reliance on this authorization. Any information received by Anthem Blue Cross pursuant to this authorization is subject to restrictions on disclosure to others as set forth under Federal and state laws.

Return this form in the envelope provided or you may fax the completed form to 1-805-375-0361. If the envelope is missing return the form to the address below.

Anthem Blue Cross  
P.O. Box 9063  
Oxnard, CA 93031-9063